CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV
COVERED SERVICES AND LIMITATIONS

DEFINITION OF PRIVATE DUTY NURSING SERVICES

Private duty nursing is defined as skilled, in-home nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse. These services are rendered according to a plan of care authorized by the Department of Medical Assistance Services (DMAS) and have been certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital or nursing facility. Private duty nursing may be provided only to individuals living in the community who have been authorized to receive certain Home- and Community-Based Care Waiver or Early Periodic Screening, Diagnosis and Treatment (EPSDT) services as an alternative to institutional care. For MEDALLION recipients, prior authorization from the recipient's primary care physician is required for EPSDT private duty nursing (PDN) services.

Private duty nursing may be offered to individuals as either:

1. Continuous private duty nursing service required to supplement care rendered by a primary caregiver, or,

2. Respite care services offered as episodic relief to the caregiver of a technology assisted waiver recipient.

The policies in this manual apply to the provision of private duty nursing care rendered as either private duty nursing (continuous nursing care) or as respite care services. See "Respite Care" in this chapter for additional information regarding respite care.

Virginia offers Medicaid reimbursement for Home- and Community-Based Care services through several waivers granted by the Health Care Financing Administration (HCFA) in accordance with § 1915(c) of Title XIX of the Social Security Act (42 U.S.C. § 1396n). Section 1915(c) allows HCFA to waive certain statutory requirements in order to allow states to offer those Home- and Community-Based Care services that prevent institutionalization of Medicaid eligible individuals. Continued federal approval for waiver programs is contingent upon the state's ability to document that the population targeted to receive waiver services was, in fact, a population that would otherwise have required institutional care and that the cost of Home- and Community-Based Care services is equal to or less than the cost of such institutional care. Individuals must be preauthorized to receive services through one of the approved waivers. An individual cannot receive services from more than one waiver program or receive waiver services if these services would duplicate other care the individual receives.

Private duty nursing is available through:

1. A waiver for technology assisted individuals offered to individuals who would otherwise require hospital (for individuals under 21) or specialized care nursing facility (for those over 21) level of care; and

2. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) private duty nursing care program.

PROGRAM CRITERIA

Technology Assisted Waiver

The individual authorized for private duty nursing through the technology assisted waiver program must have a primary caregiver who accepts responsibility for the individual's health, safety, and welfare. The primary caregiver must be responsible for a minimum of eight (8) hours of the individual's care in a 24-hour period. Private duty nursing may be authorized through the technology assisted waiver for individuals who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability. The technology-assisted population may include one or more of the following categories:

1. The technology assisted individual who is younger than 21 years of age will be determined to need a medical device and ongoing nursing care when the individual meets categories A, B, or C and category D:

   A. Individuals depending on mechanical ventilators at least part of the day; or

   B. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis; or

   C. Individuals having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding; and

   D. Individuals who have been determined to need substantial and ongoing nursing care as indicated by a score of a minimum of 50 points on the objective scoring criteria (see Appendix B).

2. The technology-assisted individual who is 21 years of age or older will be determined to need a medical device when the individual meets one or more of the following categories:

   A. Individuals depending on mechanical ventilators at least part of each day; or

   B. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis.

3. In addition, regardless of age, individuals authorized for technology assisted waiver services must be individuals:

A. Who are not residents of hospitals, nursing facilities, or board and care facilities;

B. Who are financially eligible for Medicaid;

C. For whom an appropriate and cost effective plan of care can be established;

D. For whom there are no other or insufficient community resources to meet the individual's needs; and

E. For whom the individual's attending physician has certified the need for this level of care, which must include the need for private duty nursing.

Individuals can be either hospital confined, in a nursing facility, or in the community at the time of assessment for technology assisted waiver services. However, to be eligible for these services, an individual in the community or hospital at the time of assessment must be:

1. No longer eligible for private insurance coverage for alternative institutional placement. If an individual or an individual's legally responsible party voluntarily cancels any insurance plan which would have provided coverage for institutional services in order to become eligible for waiver services within one year prior to the date waiver services are requested, eligibility for the waiver shall be denied; and

2. At risk of a hospitalization covered by Medicaid.

EPSDT Private Duty Nursing

Individuals are eligible for EPSDT covered services until they are twenty-one (21) years of age. Once an individual reaches his or her twenty-first birthday, EPSDT services will end. Children with third party health insurance are not excluded from receiving coverage through EPSDT for private duty nursing services. For MEDALLION recipients, prior authorization from the recipient's primary care physician is required for EPSDT PDN services. For Medallion II recipients, the HMO is responsible for providing EPSDT private duty nursing services. All of the following criteria must be met:

1. The individual must be chronically ill or severely impaired;

2. The individual must require individual and continuous skilled nursing care to correct or ameliorate a medical condition;

3. The individual is Medicaid eligible;

4. All third party coverage of in-home nursing services is exhausted; and

5. A safe and appropriate plan of care can be developed and is medically necessary as indicated by a physician; for MEDALLION recipients, this physician must be the recipient's primary care physician (PCP).

ASSESSMENT PROCESS

Hospitalized Recipients/Nursing Home Residents

For Technology Assisted Waiver referrals, the discharge planning staff must complete the objective scoring criteria to ensure that the individual meets the minimum nursing needs (a score of 50). For Technology Assisted Waiver referrals over the age of 21 years, the discharge planning staff must evaluate the individual for eligibility of nursing services using the Technology Waiver criteria for individuals 21 years of age or older as previously described. For EPSDT referrals, the discharge planning staff must evaluate the individual for eligibility of nursing services using the EPSDT Private Duty Nursing criteria as previously described. The staff is then responsible for completing the preassessment forms (see Appendix B). A Uniform Assessment Instrument (UAI) (see Appendix B) and, if appropriate, a level II screening must be completed on all referrals over the age of 21 years. The staff must have the parent or legally responsible person sign a Consent for Release of Information form. The forms are then sent to the appropriate Health Care Coordinator at DMAS.

Once all of the information is received, the Health Care Coordinator will review the packet and, if it is determined the individual is eligible, will schedule a home visit with the parents or caregivers. A home visit is required before an individual can begin services.

Persons Residing in the Community

Technology Assisted Waiver individuals who are 21 years of age and older referred from the community must have a Uniform Assessment Instrument (UAI) completed by the local screening team (see Appendix B for a sample of this form). If appropriate, these individuals must also be referred for a level II screening. The UAI form is sent to the Health Care Coordinator. EPSDT Private Duty Nursing individuals and Technology Assisted Waiver referrals who are under 21 years of age do not require a UAI screening.

For both hospitalized recipients and those at home, a Care Coordination Team will assess the individual's need for services and develop a plan of care based on the supports available and the needs of the individual. As part of the development of the plan of care, the Health Care Coordinator will contact the nursing provider chosen by the individual or individual's family to provide orientation to the needs of the individual to facilitate a smooth transition to nursing services. The Health Care Coordinator will continuously monitor the individual's status and the provision of nursing services by telephone contact with the nursing provider and review of documentation routinely submitted by the nursing provider.

AUTHORIZATION FOR MEDICAID PAYMENT OF PRIVATE DUTY NURSING SERVICES

The Health Care Coordination Team is the authorization mechanism for Medicaid-funded home- and community-based care services for technology assisted/EPSDT individuals. The team is made up of a physician, a health care coordinator, and other specialists as appropriate. For MEDALLION recipients, the coordinating physician must be the MEDALLION PCP or must have obtained a referral from the MEDALLION PCP. The Health Care Coordination Team uses an assessment and plan of care instrument developed specifically for the technology assisted/EPSDT population. (See Appendix B for a sample of this form.)

The pre-admission assessment of individuals requesting technology assisted waiver or EPSDT private duty nursing services by the Nursing Home Pre-Admission Screening Team or Health Care Coordination Team and preauthorization of private duty nursing services by DMAS are mandatory before Medicaid will assume payment responsibility of private duty nursing services.

Medicaid will not pay for any private duty nursing services delivered prior to the effective date of the individual's plan of care approved by DMAS. The date of this authorization cannot be made prior to the date on which the assessment is completed and DMAS makes a decision.

Medicaid will assume payment responsibility for private duty nursing services only after the Department of Social Services (DSS) has determined that the individual is Medicaid-eligible for medical assistance for the dates services are to be provided.

For recipients enrolled in the Medallion II HMO program, the HMO will coordinate and authorize PDN services with the recipient’s health care team.

FORMS REQUIRED FOR ADMISSION TO PRIVATE DUTY NURSING SERVICES

The Health Care Coordination Team which is initiating a referral, will send the provider an admission package which has been approved by DMAS (see Appendix B for samples of these forms). This admission package consists of:

- The assessment package, which consists of the Virginia UAI for individuals 21 years and older, an individual needs assessment, home/environmental assessment, and social/familial assessment;
- The plan of care, which contains the authorization for technology assisted waiver/EPSDT recipients;
- A Consent Form for Release of Information (DMAS-20); and
- A Rights and Responsibilities Form.

These forms must be thoroughly completed by the Health Care Coordination Team and forwarded to the private duty nursing agency once DMAS approval is obtained. Screening/Health Care Coordination Teams will make private duty nursing referrals only to agencies which have met Medicaid requirements and which are enrolled under contract as Medicaid private duty nursing provider agencies.

DMAS-122 FORM

The Health Care Coordinator is responsible for notifying the city or county Department of Social Services (DSS) in which the individual resides, via a DMAS-122 form, of all admissions to or discharges from the technology assisted waiver program. The DSS eligibility worker must complete the DMAS-122 form and return it to the Health Care Coordinator. The Health Care Coordinator is responsible for sending a copy to the private duty nursing provider in the event the individual has a patient pay requirement.

PRIVATE DUTY NURSING AGENCY RESPONSE TO REFERRAL

The provider agency shall not begin services for which it expects Medicaid reimbursement until the admission package (the assessment and plan of care) is received from the Health Care Coordination Team or before the date of authorization. The authorization date is shown on the Technology Assisted Services Plan of Care form.

Upon receipt of a referral and prior to the delivery of private duty nursing services, the registered nurse supervisor of the provider agency must make an evaluation visit to the recipient's home. During this initial home visit, the registered nurse supervisor is responsible for the following activities:

- Introduction of the nurse(s) to be assigned to the recipient - If the nurse to be assigned to the recipient has previously been oriented to that recipient's care or has rendered care to another recipient with the same needs as the newly assigned recipient, the nurse supervisor does not have to introduce the regularly assigned nurse at the time of services initiation. The nurse's skills checklist (DMAS 259) maintained in the personnel file must indicate previous orientation to the recipient's needs. If the nurse to be regularly assigned is not introduced to the recipient at the time of the nurse supervisor's initial home visit and the nurse has not been previously oriented to the care needs of that recipient, or a like recipient, the nurse supervisor must make a return visit with the regularly assigned nurse; and

- Discussion of the recipient's needs and reviewing the treatment plan with the recipient or recipient's primary caregiver and the private duty nurse(s) to ensure that there is complete understanding of the services that will be provided. A copy of the treatment plan must be kept in the recipient's home. The nurse(s) should be instructed to use the treatment plan as a guide for daily service provision. The nurse must chart private duty nursing tasks which are not included in the recipient's treatment plan if the recipient has a need for the task to be done. The nurse must note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the RN

supervisor who must review nursing notes to determine whether there is a need for the task to be included in the treatment plan on an ongoing basis and to make whatever changes are appropriate.

The evaluation visit must be documented in the Nursing Status Report as an initial assessment. This initial assessment should document the following:

- Introduction of the nurse to the recipient - The RN supervisor must note when the nurse(s) was oriented to the recipient's needs and when the review of the plan of care and documentation needs was conducted;

- Review of the recipient's treatment plan with nursing staff and recipient; and

- Completion of an assessment, to include the recipient's current functioning status, current medications, social support system, other community services rendered to the recipient, and condition of the recipient's environment. When any special medical care (e.g., ventilator care) is to be provided by the private duty nurse, the RN supervisor must indicate in the initial Nursing Status Report what care the nurse is providing, what instructions the nurse has received from the RN supervisor regarding this care, and the RN supervisor's observation of the nurse's demonstration of the correct techniques involved in this care.

It is the private duty nursing provider's responsibility to determine whether the agency can adequately provide services to an individual prior to accepting a referral for services from a Health Care Coordination Team. However, there may be instances in which the provider is unaware of a problem which will prohibit service delivery until the RN supervisor completes the initial assessment.

If, during the initial assessment, the RN supervisor determines that the recipient is not appropriate for private duty nursing services because of safety, health, or welfare reasons or because the provider is unable to staff the case, the agency should not open the case to private duty nursing. The provider RN should contact the Health Care Coordinator to discuss the situation. If the provider agency decides not to accept the referral, the RN must notify the recipient and Health Care Coordinator of this decision and the reason for the decision.

For EPSDT MEDALLION recipients, the private duty nursing provider must send copies of all assessments and copies of all care plans to the recipient’s primary care physician.

PROVISION OF PRIVATE DUTY NURSING SERVICES

First 30-Day Period – Technology Assisted Waiver

For recipients under 21 years of age, during the first thirty (30) days of an individual's entry into the technology assisted waiver program, private duty nursing may be offered and reimbursed by Medicaid for up to 24 hours per day if needed and appropriate to assist the family in adjustment to the complex and demanding care of the individual at home. If the individual is entering the program from the community, it is assumed the primary caretaker

is already familiar with the care of a technology assisted individual and would require less than 24 hours of private duty nursing per 24-hour period for the initial 30 days.

First 30-Day Period – EPSDT PDN

For EPSDT recipients, the number of hours authorized will be based upon medical necessity and cost-effectiveness.

Subsequent Private Duty Nursing Services Provision for the Technology Assisted Waiver

After the first thirty (30) days, DMAS will reimburse for a maximum of 16 hours per 24-hour period per household for private duty nursing. For individuals over the age of 21 years, whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household, provided that the cost effectiveness standard is not exceeded for the individual's care.

In no instance will DMAS approve an ongoing plan of care or multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.

The Health Care Coordinator has the authority to approve or deny a private duty nursing provider's request for a change in the amount or type of nursing care.

In order to ensure the health, safety, and welfare of the individual, a maximum of 16 hours of care can be provided by the same nurse within a 24-hour period.

Congregate Private Duty Nursing

Congregate private duty nursing must be provided when more than one technology assisted waiver/EPSDT recipient resides in the same home. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver/EPSDT recipients. When three or more waiver/EPSDT recipients share a home, ratios will be determined by the combined needs of the recipients.

TRANSPORTATION OF MEDICAID RECIPIENTS

Nurses should not transport technology assisted waiver/EPSDT recipients. These recipients are receiving nursing services because they are at risk of death or permanent disability without continuous nursing service. It is impossible to provide nursing services to a person while the nurse is driving a car. DMAS will reimburse for necessary transportation to medical appointments; however, transportation to school, babysitters, or other locales is the responsibility of the primary caregiver. DMAS may not be billed for any time a nurse spends driving a recipient.

MAKE UP OF MISSED SHIFTS

If the nursing agency is unable to staff a shift, it has a responsibility to try to make up the missed hours within 72 hours of the missed shift. However, if the agency is unable to make

up the missed hours during this time period, the hours cannot be made up at a later date. It is the responsibility of the nursing agency to notify the caregiver if a shift cannot be staffed.

PERSONAL ASSISTANCE SERVICES FOR TECHNOLOGY ASSISTED WAIVER RECIPIENTS

Provided that the cost effectiveness standard will not be exceeded, personal assistance services can be covered for individuals over the age of 21 who require some assistance with activities of living and instrumental activities of daily living but also are able to do without skilled interventions for portions of their day. Personal assistance services must be rendered by a provider who has a DMAS agreement to provide private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers, personal care attendants, or registered or certified respiratory therapists. These services are billed under the private duty nursing provider number.

PLAN OF CARE REVISIONS

The Health Care Coordinator is responsible for authorizing any change in the amount or type of nursing care. The nursing supervisor can request an increase or decrease in nursing hours by writing or telephoning the Health Care Coordinator. The Health Care Coordinator will authorize the change by signing and dating the Private Duty Nursing Plan of Care form and sending a copy to the nursing agency. This copy must be retained in the recipient's file. The Health Care Coordinator will notify the individual by letter of the change in hours and his or her right to appeal.

TERMINATION OF PRIVATE DUTY NURSING SERVICES

Since the definition of the technology assisted population includes the individual's need for a medical device to compensate for the loss of a vital body function, the weaning of an individual from such a device will necessitate the individual's termination from waiver services. Weaning may be a process which occurs over a period of weeks and should be accompanied by a concurrent tapering off of private duty nursing. DMAS will determine that the individual has been weaned according to the date the attending physician certifies that the individual no longer requires the medical device to avert death or further disability. DMAS may allow the individual to continue to receive some private duty nursing for a brief period not to exceed two weeks past this date for medical monitoring. A recipient will be discharged from private duty nursing services when he or she no longer meets a minimum score of 50 on the objective scoring criteria.

EPSDT recipients will be discharged from private duty nursing services when they no longer meet the program criteria as previously defined in this Chapter.

Providers should give a minimum of five (5) days' notice to caregivers when discharging recipients from services if discharge is not due to health, safety, or welfare issues.

RIGHT OF APPEAL

The Health Care Coordinator, by letter, must inform the individual of any decision to revise or terminate authorization for private duty nursing services and indicate the reason(s) for the decision. Any individual wishing to appeal should notify the Appeals Division, Department of Medical Assistance Services, in writing, of his or her desire to appeal within thirty days (30) of receipt of the Health Care Coordinator's decision letter. Appeal requests should be sent to the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. If an appeal is filed before the effective date of this action, services may continue during the appeal process. However, if this decision is upheld by the Hearing Officer, the recipient may be required to reimburse the Medical Assistance Program for the cost of Private Duty Nursing services provided after the date of DMAS termination.

When a request for an appeal is received, the Appeals Division will send a letter to the recipient and a copy to DMAS validating the appeal and scheduling a hearing. The Appeals Unit will be responsible for determining the relevant parties to be involved in the hearing process.

If the recipient files an appeal before the effective date of the action, the hearing officer notifies the recipient in writing that services can continue unchanged during the appeal and that the recipient should contact the Appeals Division if he or she does not wish services to continue. A copy of this letter is sent by the Appeals Division to the provider and the DMAS Health Care Coordinator/Utilization Review Analyst assigned to the case to inform all parties of the continuation of services.

The hearing officer will send the decision and all the exhibits to the appellant. This is the agency's final administrative action. If the appellant disagrees with the hearing officer's decision, he or she may request a review of the decision by his or her local circuit court. Information concerning the circuit court review will be included with the hearing officer's decision.

RESPITE CARE

Respite care is the provision of skilled nursing care to a technology assisted individual for short period(s) of time (a maximum of 15 days or 360 hours per 12-month period), as a supplement to the daily plan of care. Caregivers are strongly encouraged to use respite carefully and reserve some time for use in case of emergencies. Respite care must be provided in the home of the individual's family or caretaker.

The purposes of respite care are:

- To relieve the family of the care of the waiver recipient;
- To meet planned or emergency family needs; and
- To provide the restoration or maintenance of the physical and mental well being of the recipient and the family.

The focus of services offered under respite care is on the need of the caregiver for temporary relief. This focus on the caregiver and the temporary relief needed differentiates respite care from programs which focus on the dependent or disabled care receiver.

Although the recipient of respite care services must meet the same long-term care criteria for respite care as for private duty nursing, the need for private duty nursing services must be continuous, whereas the need for respite care is periodic. Also, respite care can only be authorized when there is a primary caregiver living in the home with the individual.

At the time that respite care services are needed for a specific reason, authorization may be requested. The type of authorization will depend upon the individual circumstances of the caregiver and care receiver. In all instances where authorization of respite care is given, clear documentation of the need for the amount and type of respite care authorized must be provided.

Respite care provided by a private duty nurse must follow the same policies and procedures as those established for private duty nursing in this manual.

Note: Respite care is not a covered service under EPSDT Private Duty Nursing.

CHANGES TO THE AUTHORIZATION PROCESS FOR DURABLE MEDICAL EQUIPMENT (DME)

Providers must have a completed and signed Certificate of Medical Necessity (CMN/DMAS-352) for all durable medical equipment (DME) and supplies (effective March 1, 1999). Signed delivery tickets will not be required as part of the preauthorization process. However, proof of delivery will be verified upon post payment review. If a recipient requires an item that needs preauthorization, the provider must call DMAS' contractor, WVMI, with the appropriate information. WVMI will approve, deny, or pend the preauthorization request. Items that do not require preauthorization may be provided to the recipient in accordance with regular DME policy. Any item which requires preauthorization and was previously authorized as part of a recipient's monthly rate must be preauthorized by WVMI with a separate preauthorization number (effective March 1, 1999). Failure to obtain this preauthorization will result in the denial of payment.

Preauthorization Process

WVMI conducts preauthorization functions under contract with DMAS. Preauthorization (PA) may be obtained by calling WVMI at (800) 299-9864 or (804) 648-3159. Another option is submitting a paper preauthorization request (DMAS-351). WVMI may request that certain documentation or an entire request be faxed. Telephonic or paper preauthorization must be obtained prior to rendering services. When preauthorization is requested, WVMI will inform the provider of the PA status (approve, deny, pend, or reject). If the PA request is approved, WVMI will indicate the number of units approved. If services are needed beyond this time frame, the provider must call (or submit a DMAS-351) and request PA prior to the end of the previously approved units. Any services provided without PA will not be reimbursed.

The only exception to preauthorization requirements is retroactive eligibility. The provider may request retroactive PA in these cases either telephonically or in writing (DMAS-351).

The purpose of preauthorization is to validate that the service requested is medically necessary and that it meets DMAS criteria for coverage. Preauthorization does not automatically guarantee payment for the service; payment is contingent on passing all edits contained within the claims payment process, the recipient's continued Medicaid eligibility, and the ongoing medical necessity for the service being provided. For services to be paid, all preauthorization criteria must be met. Authorizations are specific to a recipient, a provider, a service code, and an established quantity for specific dates of service. If a submitted claim for a service requiring preauthorization does not match the authorization exactly, the claim will pend for review or be denied.

To submit a preauthorization request on paper, mail the DMAS-351 PA request form and supporting documentation to FIRST HEALTH Services Corporation, the DMAS fiscal agent. The address is:

FIRST HEALTH Services
P.O. Box 27444
Richmond, Virginia 23261-7444

FIRST HEALTH Services will data enter the paper request for PA and forward it to WVMI. Make telephonic requests for PA directly to WVMI.

APPROPRIATE USE OF HOME HEALTH VERSUS WAIVER SERVICES

Home health providers must determine whether an individual referred for home health skilled nursing or homemaker home health aide services has been screened and authorized for services under one of the waiver programs. **DMAS does not consider skilled nursing and home health aide services under the Medicaid home health program to be reasonable and necessary for reimbursement purposes in those instances where the individual qualifies for the comparable service(s) available under one of the Home- and Community-Based Waivers.** While individuals may qualify for services under more than one program category, it is essential to the well being of recipients and the cost effectiveness and integrity of the programs that recipients are directed to the best possible alternatives.

Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a homebound patient. The services must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to establish a program to restore or maintain functions which have been lost or reduced by illness or injury. Home health aide services are intended to assist the patient or caregiver during a period of time that the patient or caregiver is adjusting to a change in the patient's ability to conduct his or her activities of daily living.

Private duty nursing, personal care, and respite care are services delivered by Medicaid-approved providers on an ongoing basis to individuals who qualify for technology assisted

waiver services. When an individual has **ongoing** skilled nursing or aide service needs which are available under a Medicaid waiver program, and the individual meets the criteria, the nursing or aide services must be provided through the waiver rather than through the home health program.

If the individual has been authorized to receive waiver services, and the home health provider receives a request for nursing or aide services, the home health provider must refer the individual to the DMAS health care coordinator to discuss the nursing care which is needed but not already provided by the private duty nursing staff in the home. Home health services are not appropriate for reimbursement for an individual who receives technology assisted waiver service.

The Home- and Community-Based Waiver provider and the Pre-Admission Screening Team are responsible for determining whether an individual is receiving services through home health at the time that waiver services are initiated. If the provider or Pre-Admission Screening Team is made aware that an individual receives home health services which are comparable to services available under the waiver, the provider or Pre-Admission Screening Team must notify the home health provider and facilitate transfer of the nursing or aide services to the available waiver service program.

TRANSFER OF PRIVATE DUTY NURSING SERVICES

The private duty nursing agency must transfer a recipient's care to another private duty nursing agency whenever the agency is no longer able to sufficiently staff the recipient's care or the recipient requests a transfer to another agency.

When this occurs, the private duty nursing provider is instructed to contact the Health Care Coordinator to inform of the need to transfer the recipient, the provider chosen to accept the transfer, and the effective date of the transfer. The transferring private duty nursing provider must send to the accepting private duty nursing provider a letter stating the last date of service to be rendered by the transferring provider and the reason for the transfer, along with a copy of the current plan of care, the individual's waiver assessment, authorization package, the most recent monthly nursing assessment, and the number of respite hours used within the current year. A copy of the letter must be sent to the Health Care Coordinator.

TRANSFER TO NURSING FACILITY LEVEL OF CARE

An individual entering a nursing home who anticipates Medicaid payment by DMAS for a bed must first be screened to determine whether that person meets established Medicaid criteria. When an individual is expected to enter a nursing home directly from community-based care provided under a Medicaid waiver, additional screening must be done by DMAS even though that person was originally screened by a community screening team or by a hospital screening team.

Individuals who have been receiving community-based care immediately prior to entering the nursing home (including personal care, respite care, adult day health care, or AIDS waiver) must receive authorization for nursing home level of service by DMAS. This must

be completed before the individual is admitted to a nursing home if Medicaid funding is expected. After the individual has been admitted to the nursing home, the screening cannot be done. It is strongly recommended that individuals and their families be apprised of this information, both at the time the care is initiated by the provider agency and at the time nursing home placement is being planned.

The additional information to be submitted to DMAS must include the UAI form, a cover letter, and the cover sheet entitled Community-Based Care to Nursing Facility. No other information is needed for the prescreening if the individual has been receiving community-based care immediately prior to entering the nursing home. The DMAS-95 form (rainbow colored sheets) is no longer acceptable for screenings. A UAI form must be completed for this screening if one has not previously been done for the recipient in question. The updated UAI form must include the following information. Send DMAS a copy of the UAI, not the original. The agency providing the community-based care must submit this information. Special attention to the following items is needed:

- Provide the reassessment date (Page 1);
- Provide the Social Security Number, birth date, and current correct address, including the ZIP Code, for the patient or client;
- Make sure all information is legible and complete. (The original approval letter is sent to the client's address from the DMAS office.); and
- Update all information pertaining to functional needs, medical and nursing needs, medications, and orientation, (Pages 4, 5, 6, 7, and 8), as indicated, with the date of the reassessment. If no changes have occurred since the original completion of the UAI, a comment to this effect must be noted and dated.

The accompanying cover letter must include the following information:

- Why the client is currently appropriate for nursing home placement rather than continuing in community-based care; and
- A brief summary of the individual's medical and nursing needs, including the diagnosis and any conditions requiring specific medical attention.

Recipients with Mental Illness and Mental Retardation

For recipients having a Mental Illness (MI) or Mental Retardation (MR) diagnosis which requires a Level II assessment, an additional assessment procedure beyond the assessment completed by DMAS is required. Consequently, these screenings require an extended period of time for completion. It is vital that a diagnosis of MI/MR be specifically noted in the accompanying letter when the screening request for nursing home placement is submitted. The Level II screening must be completed prior to admission for all persons with a diagnosis or history of mental illness, mental retardation, or related conditions.

Submit the information for these screening reviews to:

Long Term Care Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

- **Do Not Send** these screenings to the DMAS office in enrollment envelopes or with enrollment packets. These envelopes go directly to the person processing enrollments, and any information intended for any purpose other than enrollments may not reach the intended destination until a much later date. If the screening information has been faxed in, no hard copies are needed.

- The decision letter, the new DMAS-96, and the MI/MR form will be mailed directly to the requesting CBC agency. The provider requesting the pre-admission screening must supply the updated UAI and any additional screening materials needed by the nursing home to that facility. A facsimile of the approval letter, the new DMAS-96, and the MI/MR form will be faxed to the appropriate nursing home **if there is a bed on hold**.

- In some situations where beds are on hold, verbal approval may be given by DMAS prior to the faxing of the approval letter. This is done by phone, directly to the nursing home.

Nursing home pre-screenings should be submitted to the DMAS office as soon as the placement is anticipated rather than waiting until a bed is available. If a bed becomes available unexpectedly, DMAS must be apprised of the bed hold status in order for the review to be expedited. Currently, the turnaround time for approvals on "bed hold" is up to 72 hours, although all attempts are made to decrease that time.

Approvals

Screening approvals are valid for 12 months from the date of the approval letter. However, approvals older than 90 days must be updated with an addendum letter specifying that the condition of the patient has remained the same or has deteriorated since the time of the reassessment. This addendum letter must be submitted to the DMAS office (Nursing Facility Screening Team) for its records. In addition, a copy must be provided to the admitting nursing home. If the patient's condition has improved since the most recent approval, the UAI must be updated and submitted to the DMAS office for additional review and approval before admission to the nursing facility.